STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH DIVISION
EMERGENCY MEDICAL SERVICES
4150 TECHNOLOGY WAY, SUITE 101
CARSON CITY, NEVADA 89706
(775) 687-7590

Emergency Medical Services Training Grant Application

Please complete the following application by typing or printing clearly.

Agency Name (Must be a Volunteer Agency): _____

Training to be conducted (CPR, BTLS, PEPP, ect)_____

Amount of funding requested: $_____ (Maximum $2,500.00)

Local Government Agency to receive and administer the funds (If different from above):_____

Address: _____ _____
(Street) (City) (State) (Zip) (Tax I.D. #)

Authorized Local Official:_____
(Print Name)

Authorized Local Official:_____ Date:_____
(Signature)

Training Program Coordinator:_____
(Day time phone #)

Address: _____
(Street) (City) (State) (Zip)

Email address:_____@_____

In addition to this application please submit (on agency letterhead) a brief explanation of the need for this training program and; the following information:

- A description or outline of the educational program to be conducted with a list of goals and objectives
- The number of EMS personnel expected to participate in the training
- A brief description of the geographic area to be served by the training
- A detailed budget that shows the total costs of the training program.

Return application and required documentation to:
Nevada State EMS
Attention: Connie McFadden
4150 Technology Way, Suite 101
Carson City NV 89706
Phone: (775) 687-7590 Fax: (775) 687-7595

EMS Office Use Only

Date Received: _____ Reviewed By: _____

Approved: _____ Amount Recommended: _____

Denied: _____ Reason for denial: _____

EMS Program Director: _____ Date:_____ Approved_____ Denied_____

Amount authorized:_____ Budget/Category: _____